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on
MEDICARE+CHOICE MARKETING AND APPEALS
before the
SENATE SPECIAL COMMITTEE ON AGING
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Chairman Grassley, Senator Breaux, distinguished committee members, thank you for inviting me to discuss oversight of Medicare+Choice plan marketing and response to beneficiary appeals of care denials. I would also like to thank the General Accounting Office (GAO) for its reports, which will help us improve enforcement of requirements for plans in these two important areas.

Managed care and the other types of private insurance plans that comprise Medicare+Choice are important as voluntary options along with original fee-for-service Medicare. We are committed to ensuring that Medicare+Choice continues to grow and flourish. For Medicare+Choice to succeed, beneficiaries must receive accurate information about plan benefits, rules, and rights to appeal denials of coverage. We are striving to meet this objective with our National Medicare Education Program. It is incumbent upon health plans, as our partners in this effort, to work with us to ensure that beneficiaries receive accurate information. However, as the GAO reports make clear, misinformation and abuses in marketing and of beneficiary appeal rights have not been adequately addressed.

In 1997 and 1998, the Health Care Financing Administration (HCFA) issued managed care marketing guidelines and established the strongest appeal rights for managed care beneficiaries anywhere in the country. However, the new GAO reports make clear that we must do more to ensure that beneficiaries receive accurate information about their rights and options.

First, we must send a loud and clear message to the industry that we are taking enforcement very seriously. We will start by investigating the violations identified by the GAO and impose sanctions where appropriate.

Today, I am announcing that we are taking several additional steps to strengthen oversight and enforcement, many of which are already underway.

- We will no longer assume that plans have made required changes without seeing the corrected documents ourselves.
- We will soon implement a pilot project to determine whether centralized review of marketing materials by an independent contractor will improve the process. Our expectation is that centralized review by fewer people will result in more uniform decisions, and that use of an independent contractor will provide HCFA staff with more time for other oversight activities. We have already let a contract and selected 12 plans to participate in this demonstration, which we expect to begin soon.
- We are well on our way to implementing standard formats and language for use in the Summary of Benefits documents that plans provide to beneficiaries. This action was recommended to us by this Committee last year, and we believe it will enable beneficiaries to make apples-to-apples comparisons among plans more easily. We expect to release a draft for public comment this Spring, and will require plans to use the standardized Summary of Benefits in time for this Fall's open enrollment season.
- We will be consumer testing model language for enrollment, appeals, and care denial forms. Once we are sure that this model language is clear and helpful to beneficiaries, we will require that

standardized forms be used by plans.

- We are moving to require plans to use a standardized format for submitting the detailed information about benefits, premiums, and cost-sharing. This is the information that we use to review the accuracy of marketing materials and the financial soundness of benefits packages. The new format will reduce the need for separate data collection and verification efforts. It will help flag plan policies that violate Medicare policy, for example, requiring a referral for mammography. And it will make it easier for the independent contractor that hears beneficiary appeals to make judgments based on a clear, standardized description of plan benefits and rules.
- We are defining requirements for a new system to monitor appeals at the plan level, which until now have never been tracked by HCFA.
- We require that all denial notices be in writing, include a detailed explanation of why care does not meet coverage criteria, and explain enrollee appeal rights.
- We will issue a proposed regulation detailing when and how beneficiaries must be notified that services, such as skilled nursing facility care, are being reduced or discontinued by the plan.
- And we are revising our protocol for monitoring plans to specifically address whether a plan and its provider groups handle appeals as required.

Marketing

An important information tool that Medicare beneficiaries use when choosing Medicare+Choice plans is called the Summary of Benefits. In the past, plans have been given wide discretion in developing their particular plan benefit descriptions. As a consequence, the material provided to beneficiaries has varied widely from plan to plan in format, content, and terminology. As this Committee has pointed out, this variation has made it difficult for beneficiaries to make easy comparisons of benefits offered by different plans.

To address this variation, we have been working in consultation with beneficiary advocacy groups, the health plan industry, State regulators, and the Federal Trade Commission to develop a standardized plan benefit document. This new standardized document will govern coverage and benefit information and materials distributed to beneficiaries by managed care plans. It will be based on a universal, menu-driven template that allows health plans to choose from a list of items applicable to its offerings. The form will contain three main sections:

- a beneficiary information section, providing information on the Medicare managed care program in general terms;
- a benefit comparison section informing beneficiaries of the benefits offered as compared to original, fee-for-service Medicare; and
- a special features section where plans may provide additional information, such as provider network information, clinic location maps, graphics, etc.

Beginning with the November 1999 open enrollment period, all Medicare+Choice plans will be required to use this standardized format when describing or comparing their benefits in marketing activity. We expect to distribute the new standardized format to all plans by the end of May 1999, after which we will conduct training sessions on how to use the format.

In addition, after consulting with beneficiary groups and plan representatives, we will require standardization of other beneficiary notification materials, including enrollment application forms and materials related to complaints. We anticipate that these new standardized materials will be ready for use in the Fall of 2000 for the annual beneficiary education campaign.

Currently, review of plan marketing materials is conducted primarily by staff in HCFA's ten regional offices across the country, in coordination with HCFA's central office in Baltimore. We share the concern of the GAO and the managed care industry regarding the inconsistency in our marketing review decisions and our interpretations of national marketing regulations and guidelines. We are aware that the subjectivity of different regional office reviewers has in the past led to different approval or rejection determinations by multiple reviewers on identical, or nearly identical, marketing materials. In addition, local market operational factors that affect health plans and regulators at the local level have influenced the reviewers' interpretation of regulations. Our review process must be improved so that conflicting review of plan materials is minimized and consistency and uniformity in decision-making is maximized.

One key step in improving the current process is to revise how plans transmit the plan benefit information to HCFA at the outset. In the past, such information has been supplied by the plans in multiple formats and with non-standardized terminology to describe the benefits provided by the plan. This has made it difficult for HCFA review staff to determine the actual type and scope of benefits provided by the plans.

As mentioned above, to address the inconsistency in the information provided by plans and the reviews conducted by HCFA staff, we have developed a new standardized form for plans to use in providing detailed descriptions of their benefit package to us. This new form will provide us with more detailed benefit information in a standard format, using standard terminology to facilitate a more accurate and consistent review of marketing materials. This standardization promotes our goal of providing beneficiaries with accurate information with which to make health plan decisions by assisting our review staff in determining whether plan marketing material complies with current Medicare law, and ensuring that plans are indeed providing the benefits they are marketing to beneficiaries.

Furthermore, the new standardized format will assist our independent contractor that hears appeals which have been rejected by plans to more quickly and accurately adjudicate beneficiary appeals. When beneficiary coverage disputes arise, the standardized format will allow the independent contractor to readily determine the scope of the plan's benefit package, as well as any exclusions or fees associated with the disputed benefit or coverage decision.

We anticipate that the new standardized form for transmitting benefit information will be fully implemented in 2001, as recommended by the GAO.

In addition to steps mentioned above, we are taking the following steps to further improve our plan marketing review process:

- directing our Medicare Managed Care Marketing Product Consistency Team, which includes representatives from HCFA's ten regional offices and our central office, to review and actively address the GAO findings;
- requiring annual training sessions for HCFA staff engaged in Medicare managed care marketing review activities whenever new marketing policies are implemented; and
- updating the Medicare Managed Care National Marketing Guide, in consultation with the managed care industry and beneficiary advocacy groups, for use in the marketing material review process.

We recognize and acknowledge the importance of establishing standard formats and common language for all managed care appeal-related information.

- Recently, we gave all managed care plans model language for the Notice of Discharge and Appeal Rights form issued by plans. This notice informs all beneficiaries in inpatient hospital settings of their appeal rights when they are discharged from the facility.
- We are developing model language for service and payment denial notices issued by plans, and are requiring that the denials be made in writing by the plan and explain in detail why the care does not meet the plan's coverage criteria.
- And, in collaboration with the regional offices, we have developed model language for enrollment letters and forms sent to enrollees by managed care plans. This model language will ensure that plans meet all of our enrollment notification requirements when they distribute this information to eligible enrollees.

This model language is currently undergoing consumer testing. Once refinements are made to the language and we are confident that the language is understandable to beneficiaries, we will require all plans to use this standard language.

Appeals

Effective and efficient systems to appeal managed care plan coverage denials are essential. The Clinton Administration has made appeal rights for Medicare+Choice beneficiaries among the strongest for any managed care enrollees in the country, and it is incumbent upon us to ensure that these rights are enforced. Since August 1997, plans have been required to:

- respond within 72 hours on appeals of care denials that could jeopardize life, health, or ability to regain maximum function;
- respond within 30 days to all other appeals of service denials;
- state the reasons for a denial in writing;
- use denial notice forms that describe beneficiary appeal rights;
- accept oral requests for expedited appeals;
- follow up verbal notifications in writing within two working days;
- grant automatically all physician requests for expedited appeals; and
- maintain logs and periodically report on requests for expedited appeals.

Since the federal government is the largest purchaser of managed care, our expedited appeals regulation for urgent care cases set a new, higher standard for the entire managed care industry.

All appeals rejected by plans are automatically forwarded to our independent appeals contractor for independent review, with no monetary threshold or other barrier. This independent contractor, currently the Center for Health Dispute Resolution, is also required to act on expedited appeals within 72 hours, and within 30 days for all other service denials.

Beneficiaries have up to 60 days to appeal decisions of the independent review process to the Department of Health and Human Services Administrative Law Judges. These appeals must involve at least $100, and there is no time limit on Administrative Law Judge action. Beneficiaries have up to 60 days to request a review of Administrative Law Judge rulings by the Department of Health and Human Services Appeals Board. Finally, beneficiaries have up to 60 days after an Appeals Board decision to request federal district court review for cases involving at least $1000.

Medicare+Choice beneficiaries are informed of their appeal rights at the time of initial enrollment, upon every denial of service or payment, in notices provided when they are admitted and discharged from hospitals, in the annual *Medicare & You* handbook, and in the detailed description of benefits plans

provide known as the Evidence of Coverage. Enrollees also can get information by calling our toll-free telephone service at 1-800-MEDICARE (1-800-633-4227).

Medicare also provides extensive appeal rights in fee-for-service, where most appeals are filed by providers. But managed care appeals are essential to beneficiaries because the incentives are so very different and denials come before, rather than after, care is delivered. Beneficiaries must be confident that managed care incentives to reduce unnecessary care will not be allowed to limit appropriate care, and we are committed to strengthening and refining the Medicare+Choice appeals system as appropriate.

The GAO report highlights areas where the Medicare+Choice appeals system can be refined and our oversight strengthened. We generally concur with the report's recommendations and will work to implement them.

Our beneficiary research tells us that the vast majority of beneficiaries are satisfied with the care Medicare+Choice plans provide, and have never filed appeals. Until now we have not gathered statistics on appeals at the plan level. We do know now that in 1998, with more than 6 million beneficiaries in managed care plans, our independent appeals contractor reviewed only 14,745 cases. Of these, 22 percent were decided in the beneficiary's favor. We recognize that the appeals process will become more important when beneficiaries, under the Balanced Budget Act, are no longer allowed to disenroll from plans on a monthly basis.

We are now requiring plans to collect data and, as of January 1, 2000, report to beneficiaries the number of appeals filed, the number decided in beneficiaries' favor, and the timeliness of the process. We will be collecting this and other appeals data ourselves, including:

- how many cases are resolved at the plan level;
- the average and maximum length of time each plan takes to resolve appeals;
- the percentage of plan rulings that occur within the mandated time frames;

This and the other information we will collect will help us:

- better monitor plan performance;
- motivate plans to improve responsiveness;
- determine whether any new plan standards need to be set or any specific interventions warranted to improve the system;
- understand the types of services being appealed;
- ensure that beneficiaries have full access to and understanding of their appeal rights; and
- target specific beneficiary groups who may need additional assistance in understanding their appeal rights.

We are surveying beneficiaries who have disenrolled from a Medicare+Choice plan to better understand the extent to which care denials and improper appeals procedures may be involved in decisions to disenroll from plans. We should have our first report of the findings by mid-2000. We also are testing a process whereby beneficiaries can request a disenrollment from via Medicare's toll-free help line, 1-800-MEDICARE (1-800-633-4227), and this will also allow us to ask beneficiaries directly why they are leaving a plan at the time they are leaving. This should provide another helpful way to monitor potential problems with plan appeals information.

We are planning to sample denied claims for further review to ensure that plans are implementing their

internal processes in the required manner. Our June 1998 Medicare+Choice regulation makes explicit that plans themselves are ultimately accountable for their appeals processes, regardless of whether they are handled by a subcontractor. And we are considering regulations to establish a standard grievance procedure to ensure consistency among all Medicare+Choice organizations.

CONCLUSION

Medicare beneficiaries and those who help them make decisions about their health plan options need and deserve accurate, reliable information. We are doing a great deal to address problems with marketing and appeals identified in the GAO reports. And we will ensure that beneficiaries receive clear and accurate information about the rights and options in the Medicare+Choice program. We appreciate this Committee's leadership in this area, and the important work that our colleagues at the GAO have done in pinpointing aspects of our program that need improvement.